Comments:

- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

1. Date of Action: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋ (M/D/Y)

2. Completed By: ⌊__⌋⌊__⌋⌊__⌋ _____

3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other

4. Visit Type:
   - ☐ 1 Screening #⌊__⌋
   - ☐ 2 Semi-Annual #⌊__⌋⌊__⌋
   - ☐ 3 Annual #⌊__⌋⌊__⌋
   - ☐ 4 Non-Routine

5. What study medication schedule did the participant follow?

HRT	__ __ pills/week
CEE 0.3 mg	__ __ pills/week
CEE 0.625 mg	__ __ pills/week
MPA 2.5 mg	__ __ pills/week
MPA 5 mg	__ __ pills/week
MPA 10 mg	__ __ pills/week
CaD	__ __ pills/week

6. What is the new study medication schedule? (Include all study medications the participant should take, including those that you are not changing.)

6.1. Medication:	6.2. Dosage:
1. ____ HRT:	⌊__⌋⌊__⌋ pills/week
2. ____ CEE 0.3 mg:	⌊__⌋⌊__⌋ pills/week
3. ____ CEE 0.625 mg:	⌊__⌋⌊__⌋ pills/week
4. ____ MPA 2.5 mg:	⌊__⌋⌊__⌋ pills/week
5. ____ MPA 5 mg:	⌊__⌋⌊__⌋ pills/week
6. ____ MPA 10 mg:	⌊__⌋⌊__⌋ pills/week
7. ____ CaD:	⌊__⌋⌊__⌋ pills/week

6.3 Is this a cyclic regimen?

☐ 0 No ☐ 1 Yes

7. Is the new study medication scheduled permanent?

☐ 0 No → 7.1. For how long should the participant follow this new study medication schedule? (Record shortest length of time if more than one medication.)

⌊__⌋⌊__⌋ weeks

☐ 1 Yes

8. Why did you make the change in the medication schedule?

8.1. HRT *(Mark all that apply.)*
   - ☐ 1 Bleeding
   - ☐ 2 Biopsy abnormality
   - ☐ 3 Abnormal transvaginal ultrasound
   - ☐ 4 Symptom intolerance *(Specify):* _____
   - ☐ 8 Other *(Specify):* _____

8.2. CaD *(Mark all that apply.)*
   - ☐ 1 Symptom intolerance *(Specify):* _____
   - ☐ 8 Other *(Specify):* _____

K_____ V_____